DIVISION OF HEALTH CARE FINANCING

COORDINATION OF BENEFITS UNIT
PO BOX 6220
MADISON WI 53716

Telephone: 608-221-4746
FAX: 608-221-4567

www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

MEDICARE MANAGED CARE
PROVIDER-BASED BILLING
IMPORTANT (Response required within 120 days)

Wisconsin Medicaid has been informed that the recipient(s) identified on the enclosed Provider-Based Billing Summary and claim(s) has Medicare Managed Care coverage for the dates of service listed. This information was received after Wisconsin Medicaid paid this claim(s).

If a recipient becomes eligible for Medicare Managed Care on a retroactive basis, the provider is required to submit certain Medicaid-paid claims to the Medicare Managed Care organization for reimbursement and follow Medicaid's policy regarding submission of crossover claims. The process Wisconsin Medicaid uses to facilitate this is called provider-based billing.

Since benefits under Wisconsin Medicaid are secondary to those provided by Medicare Managed Care, providers are required to seek reimbursement from Medicare per HFS 106.03(6) and (7), Wis. Admin. Code. Providers may not bill recipients for these services.

Return all responses from the Medicare Managed Care organization within 120 days of the date on the attached summary and include the required supporting documentation (described below) and a copy of the Provider-Based Billing Summary to the following address:

Wisconsin Medicaid
Provider-Based Billing
PO Box 6220
Madison WI 53716-0220

Providers also have the option of faxing the required information to **Medicaid Provider-Based Billing** at **(608) 221-4567**.

If Wisconsin Medicaid receives no response within 120 days, future payments will be deferred in the amount equivalent to the original Medicaid payment amount for the attached claims. The payment deferral is not considered a final action. Wisconsin Medicaid will accept documentation of the Medicare Managed Care organization's payment, denial, or nonaction after 120 days have elapsed. Therefore, it is not necessary to request a hearing. Refer to the instructions under Section C of this letter for rebilling after a payment deferral has occurred.

SECTION A — SUBMITTING CLAIMS

1. All Providers

Submit the enclosed claims (or providers may produce their own) to the Medicare Managed Care organization. Ensure that the correct Medicare provider number, Universal Provider Identification Number (UPIN), and Health Insurance Claim number (nine digits followed by a one- or two-digit alphanumeric code) are on the claims. Attach any additional documentation required by Medicare Managed Care organization.

Note: Providers are required to seek Medicare payment for all dual entitlees (eligible for Medicare Managed Care and Wisconsin Medicaid) to whom they provide Medicare-covered services. Medicare may retroactively enroll physicians who had valid Wisconsin licenses on the claim date of service.

2. Home Health Providers
Home Health providers should check the enclosed claims to determine if there are any personal care hours that should be billed to Medicare as "Home Health Aide." These hours must be billed to the Medicare Managed Care organization along with skilled services.

SECTION B — RESPONSES WITHIN 120 DAYS

1. Medicare Managed Care Payment
When Medicare Managed Care approves payment, resubmit the claim as a crossover to Wisconsin Medicaid. The original Medicaid payment should be refunded in full to Wisconsin Medicaid along with a copy of the Medicare Remittance Notice (MRN) and the Provider-Based Billing Summary page. Send this information to the address or fax number listed on the previous page.

2. Medicare Managed Care Denial
If Medicare Managed Care denies payment, send a copy of the MRN and the Provider-Based Billing Summary to the address or fax number listed on the previous page.

3. Home Health Agencies
Home Health Agencies can send the Medicare Home Health Coverage Denial Reasons form to Medicaid Coordination of Benefits if the conditions described on the form are applicable.

Note: If Medicare Managed Care denies payment because the service is not medically necessary, Medicaid also considers the service not medically necessary. Therefore, an MRN or Medicare Home Health Coverage Denial Reasons form should not be forwarded to Medicaid Coordination of Benefits to stop the deferral of future Medicaid payments.

SECTION C — RESPONSES AFTER 120 DAYS

1. Date of Service Within 12 Months
Providers should submit a new Medicaid claim through normal processing channels if the date of service is within 12 months and a payment or denial is received from the Medicare Managed Care organization. Do not use the provider-based billing claim created by Wisconsin Medicaid. Apply the appropriate Medicare Managed Care disclaimer code. These codes correspond to the Medicare Disclaimer Codes, referenced in the Coordination of Benefits section of the Wisconsin Medicaid All-Provider Handbook. (Pharmacies should refer to National Council for Prescription Drug Programs (NCPDP) billing guidelines.)

2. Date of Service Greater Than 12 Months
If the date of service is more than 12 months ago and a payment or denial is received from the Medicare Managed Care organization, providers may submit a Medicaid claim to the following address:

Wisconsin Medicaid
Timely Filing Appeals
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Do not use the provider-based billing claim created by Wisconsin Medicaid. Apply the appropriate Medicare Managed Care disclaimer code. These codes correspond to the Medicare Disclaimer Codes, referenced in the Coordination of Benefits section of the Wisconsin Medicaid All-Provider Handbook. (Pharmacies should refer to NCPDP billing guidelines.) In addition, please include documentation of payment or denial (as indicated in Section B, parts 1 and 2 of this letter) and the Provider-Based Billing Summary.

If you have any questions, contact Medicaid Coordination of Benefits at (608) 221-4746, ext. 3142.